Bellaire Neurology, PA
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Multiple No Show/Late Cancellation Policy

Patients who fail to show up for their appointments or fail to give two (2) business days notice before canceling their appointments place an extra burden on the staff of Bellaire Neurology. Furthermore, since the appointment goes unfilled, this represents either a delay to see another patient or a financial burden to Bellaire Neurology. Therefore, Bellaire Neurology has implemented the following policy:

Patients with two (2) or more "no shows" or "late cancellations" in the last ten (10) visits are required to sign this "Multiple No Show/Late Cancellation Policy" prior to scheduling their next appointment. After two missed/late cancellation appointments, this form must be returned with a credit card authorization or check prior to scheduling the next appointment. The credit card will not be charged at that time however If the patient no shows a third time or gives less than two (2) business days notice the credit card will be charged the $100 fee.

New patients who fail to show for their first appointment or reschedule/cancel with less than two (2) business days notice will be required to sign this form before scheduling a second new patient appointment. If they do not show or give proper notice for their second appointment they will be charged the $100 fee.

If the patient chooses to pay by check then a $100 deposit will placed on the patients' account. If it is used then another $100 deposit must be issued. If the $100 deposit is not used within 10 visits then a refund will be issued. It will also be returned upon patient request if they are not returning to our office. Please fill out the bottom portion of this form and fax it back to the office staff at 713-715-6367.

☐ I have read the above and understand. I agree for you to charge my credit card for $100 if I should no show or cancel less than 2 business days notice.

☐ I have read the above and understand. I will pay $100 in the form of a check or cash for you to place as a deposit on my account.

PATIENT NAME _____ DATE _____

SIGNATURE _____ NAME ON CARD _____

CREDIT CARD # _____ EXPIRATION DATE _____

BILLING STREET ADDRESS _____ BILLING ZIP CODE _____

SECURITY CODE (back of MC/VISA; front of Amex/Discover) _____

Check one: ☐ VISA ☐ Mastercard ☐ American Express ☐ Check ☐ Cash